

## Incorporating Community–Academic Partnerships into Graduate Medical Education

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Our nation's health is challenged by the persistence of health disparities, lack of universal health insurance, and increasing poverty rates. There is an unprecedented contrast between the sophisticated technology used to treat strictly "medical" conditions and the tools needed to treat problems such as obesity, substance abuse, and domestic violence, which are deeply rooted in social conditions.<sup>1</sup> Even when the knowledge base exists regarding how to treat these conditions, a gap exists in how these services are translated to the individual patient and communities as a whole. This gap is being addressed in a number of ways. Accrediting bodies at the undergraduate and graduate levels now require that community health and cultural competency be incorporated into training. Recently, the Liaison Committee on Medical Education recommended that "medical schools should make available sufficient opportunities for medical students to participate in service-learning activities."<sup>2</sup> In support of such training initiatives, federal agencies and private foundations have been promoting translational research, service learning, community-based participatory research (CBPR), and community-engaged scholarship in the health care professions. Despite these efforts, training still occurs mostly within hospital walls. Furthermore, many academic institutions remain resistant to viewing community-based education, research, and service as a credible and valid way to address the issues at hand. Community–academic partnerships, for the most part, stem from either individual, passionate leaders or the political need of a particular institution rather than being universally held as an integral part of the mission of an academic medical center.

In this issue of the *Progress in Community Health Partnerships*, we can learn from two successful initiatives geared toward creating a health care work force that can effectively

combine knowledge with action to achieve social change to improve health outcomes and eliminate health disparities.<sup>3</sup>

Doctor Earnestine Willis and her colleagues describe a successful, sustainable, integrated program for pediatric residents where the community has active participation in the design, implementation, and evaluation of the pediatric training program.<sup>4</sup> The tension between creating community projects that meet the self-identified needs of the community and the outside perceived needs of the academic institution seems to be resolved. Both community and university members learn from each other's culture; the learning is reciprocal. The use of parent trainers, described in this article, is of utmost importance in ensuring that health professionals are always in tune with the patient and community perspectives.

In Dr. Debbie Salas-Lopez and her co-worker's article, there is an important attempt at understanding health beliefs regarding cancer screening among Latinos, a group that suffers from lower screening rates even though the incidence of some cancers is higher than in the general population.<sup>5</sup> Learning the patient's perspective is an essential first step when addressing the differential diagnosis of perceived patient nonadherence.<sup>6</sup> Health care providers, and especially trainees, frequently get frustrated when patients do not follow their advice. They rarely take a step back to reflect on why this is the case. Running focus groups with patients or community members can inform providers about the barriers patients and communities face with recommended medical treatments. Issues of culture, language, health literacy, and socioeconomic constraints need to be addressed if we want our interventions to have meaningful effect. With most visits limited to a 15-minute encounter, we need to develop tools that physicians-in-training can use to elicit the information needed. Studies such as Dr. Salas-Lopez and associate's are a step toward understanding and defining

the types of skills that these physician-trainees need to learn to accomplish this.

Many challenges arise when incorporating community-academic partnerships into graduate medical education. Communities are at different developmental stages with regard to their resources, knowledge of health threats, and ability to overcome the historical mistrust existing between them and their neighboring academic center. Community agencies have to be willing to use their manpower in the training of physicians and to dedicate time to CBPR when traditionally they are service driven.

Universities have different levels of commitment to their surrounding community. Financial pressures have institutions abandoning this commitment when funding streams and prestige favor bench side research. Academic medical centers need to be willing to build research capacity at the level of community-based organizations with financial support and training. Community-engaged scholarship needs to

be recognized as a tool for academic promotion.<sup>7</sup> Throughout the process, each partnership has to determine how to balance its power differential and focus its energy on the ultimate goal of serving the community.<sup>8</sup>

Much has been accomplished in this field, but a great deal of work lies ahead. Community-academic partnerships should make it a priority to obtain outcomes data demonstrating that community-based education provides clinical trainees with skills and knowledge that have a direct impact on patient care. Medical centers should incorporate patient and community perspectives into their plans for addressing major health threats. Community health and cultural competency should be taught in all clinical disciplines, rather than solely in the major primary care fields. Medical providers, patients, and the community will all benefit if they embrace the notion that partnerships are not a threat and a burden, but rather a tremendous opportunity for improving health care delivery and eliminating health disparities.

## REFERENCES

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